Rhode Island Medicaid Managed Care Encounter Data Methodology, Thresholds and Penalties for Non-Compliance

Rhode Island Executive Office of Health and Human Services

June 2016

1. Introduction

Complete, accurate, and timely data submissions are essential to effective performance within the Medicaid managed care program. As set forth in Section 2.13 of the contract between EOHHS, contracted Medicaid managed care organizations (MCOs) are required to comply with all of the reporting requirements for encounter data established by EOHHS. This document sets forth the procedures and requirements for reporting and data submission. EOHHS reserves to right to update this document from time to time.

2. General Requirements

MCOs must submit to EOHHS complete, accurate, and timely data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with guidance provided in this document and the related appended business design documents issued on behalf of EOHHS by its contracted MMIS vendor, Hewlett Packard Enterprise. These business design documents are incorporated be reference herein and include the following guides:

Standard Companion Guides Transaction Information for Rhode Island Medicaid

1. Instructions related to 837 Transactions based on ASC X12 Implementation Guides, version 005010 Encounter Data

   Version 2.4

2. Instructions related to NCPDP Post Adjudication Transactions based on NCPDP

   Post Adjudication Standard Implementation Guide

   Encounter Data Version 2.1

3. Instructions related to 834 Transactions based on ASC X12 Implementation Guides, version 005010 Encounter Data Version 2.1

4. Instructions related to 277CA Transactions based on ASC X12 Implementation Guides, version 005010 Encounter Data Version 1.3

5. Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010

The MCO shall transmit to EOHHS or its designee, all transactions and code sets in the appropriate standard formats as specified under HIPAA and as directed by EOHHS, so long as EOHHS direction does not conflict with the law

The State reserves the right to make changes to these guidance documents at any time. Notice of changes will be provided to the MCO by EOHHS or its designated agent. The MCO is expected to implement these changes within ninety (90) days of notification. Failure to implement changes timely and to submit timely and accurate encounter data, may result in financial sanctions on the Bidder as set forth in the Medicaid managed care contract.

If the MCO delegates responsibility to a subcontractor, the MCO shall ensure the subcontracting relationship and subcontracting documentation comply with EOHHS reporting requirements. The MCO is solely responsible for ensuring that its subcontractors are in compliance with the State's requirements.

2.1 Timeliness

Encounter data must be submitted to EOHHS at a minimum monthly, and no later than thirty (30) calendar days from the end of the month in which the Contractor paid the financial liability.

The Contractor must notify the State ten business days prior to the due date of submissions if the Contractor anticipates a delay in submission/ processing and request an extension. The State has sole authority for approving or denying any extension request.

2.2 Accuracy/Integrity:

The Contractor must submit accurate and clean encounter data, ninety-nine (99%) of the time.

Submitted encounters and encounter records must pass all EOHHS's designated Medicaid management information system ("MMIS") contractor's edits with a disposition of accept and

Submitted claims must meet all standards set forth in the Standard Companion guides referenced above.

Submitted encounters or encounter records must not be a duplicate of a previously submitted and accepted encounter or encounter record unless submitted as an adjustment or void per HIPAA Transaction Standards.

The Contractor will correct and re-submit any rejected claims within 60 days of the end of the month in which the claim was paid or 30 days following receipt of the 277CA reports whichever is later.

As part of its QM/QI program, the Contractor shall review all reports and data submitted to EOHHS to identify any instances and/or patterns of non-compliance including missing/incorrect information, identify and implement actions to correct instances of such non-compliance and to address patterns of non-compliance, and identify and implement quality improvement activities to improve performance.

2.3 Data Validation

Contractor will reconcile encounter data to provider payment and to attest to its accuracy with each submission. Contractor agrees to assist EOHHS in its validation of utilization data by making available a sample of medical records and a sample of its claims data upon request.

Contractor will submit monthly reports that summarize file submission status by vendor, line of business and fiscal year in a format determined by EOHHS. The report will include, at a minimum:

1. Encounter Claims Incurred (total volume and dollars)
2. Encounter Claims Submitted (total volume and dollars)
3. Encounter Claims Accepted (total volume and dollars)
4. Number of claims and dollar value by error type (total volume and dollars)

The Contractor will submit documentation and explanation with these reports of variances of greater than 1% between and among the total value for categories 1-3 above for data outside of timely submission or correction timeframes.

3. Coordination Between EOHHS and MCOs

To facilitate and ensure effective communication and coordination among EOHHS, HP and MCOs, EOHHS will convene monthly conferences to discuss encounter claims submissions to identify and address outstanding or unresolved issues. MCOs will participate reviewing the file submission reports, documentation of variances and comparisons of accepted claims as reflected in the MMIS to incurred claims as reflected on payer-supplied submission reports. These conferences will provide the venue for problem identification in the submission and validation processes and determination of appropriate resolutions.

EOHHS shall provide the Contactor with the appropriate reporting formats, instructions, submission timetables and technical assistance, as required. EOHHS will develop and

maintain a *Managed Care Reporting Calendar and Templates* to be used as a living document of the reporting requirements.

4. Method for Calculating Compliance, Thresholds for Compliance

Section 2.13.02.05 of the Contract between EOHHS and MCOs provides for penalties in the event of continued non-compliance with contractual requirements as follows:

> ***Penalties for Non-Compliance***
>
> *At the discretion of EOHHS, Contractor may be subject to penalties for continued non-compliance with timely, accurate and resolved submission of encounter data or aggregate reporting requirements.*
>
> *EOHHS may assess penalties for non-compliance in areas that include but are not limited to:*
>
> 1. *Submissions of individual level encounter data within 60 days of the close of the month in which the claim was paid*
> 2. *Encounters that reflect paid claims and that remain in rejected status without explanation for delay for more than 30 days after the plan's receipt of the Claims Acknowledgment (CA-277) file*
> 3. *Accepted encounter claims with inaccurate or incomplete information*
>
> *At EOHHS' discretion, continued non-compliance in the areas described above will result in penalties that may range from a penalty of 0.1% of the total value of outstanding or rejected claims to a 1% general withhold on the plans' capitation rates.*

4.1 EOHHS Data Quality Team and Calculation of Compliance

The EOHHS Data Quality team shall be responsible for assessing and determining compliance. The basis for calculation of compliance shall be fully transparent to all parties. No "Notice of Intent to Impose Penalty for Non-Compliance" will be assessed sooner than ninety-days following the issuance of an updated version of this "Rhode Island Medicaid Managed Care Encounter Data Methodology, Thresholds and Penalties for Non-Compliance" guidance document. This updated version will specifically detail:

- Method for calculating compliance, including methods to ensure deficiency is due to MCO submission processes rather than deficiencies in EOHHS and/or HP processes
- Thresholds for compliance

- Effective dates of compliance review
- Penalty structure

To advance this work, the EOHHS Data Quality Team will:

- Develop a standard set of reports with weekly automation that enable routine tracking of utilization, spending, claims submission, error tracking and resolution and other key trends over time
- As applicable, this will be done by month and by fiscal year from FY14-present and will include the whole universe and by claim type, vendor, and spot checks for provider
- Results will be compared to reported financial data from the MCO
- The Data Quality team will review these reports weekly and generate discussion points for monthly meetings with plans
- Data Quality Team will work with health plan liaisons to address questions and outstanding issues before, during, and after monthly meetings
- If the gap between incurred claims and MMIS summaries persists above a given threshold for a given period after adequate allowances for resolution and root cause analysis, EOHHS leadership, Data Quality team, and liaisons will determine whether to exercise penalties according to defined terms

4.2 Notice of Intent to Impose Penalty for Non-Compliance

In all events EOHHS' preference is to resolve any issues regarding timeliness, accuracy, and completeness of submissions through a productive and collaborative process. In the event of continued non-compliance EOHHS shall provide a minimum of forty-five days written notice to the MCO of EOHHS intention to invoke penalties. This notice shall provide the basis for the determination of non-compliance and provide an opportunity for the MCO to (a) appeal and/or dispute EOHHS' determination of non-compliance and (b) cure the deficiency prior to the end of the forty-five day period